Supreme Court, U.S.
FILED
MAY 5 1997
CLERK

No. 96-1572

In The

Supreme Court of the United States

October Term, 1996

HEALTHSOUTH REHABILITATION HOSPITAL,

Petitioner,

vs.

AMERICAN NATIONAL RED CROSS d/b/a AMERICAN RED CROSS SOUTH CAROLINA BLOOD SERVICES REGION,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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RULE 29.6 LISTING

Respondent American National Red Cross is a private, not-for-profit corporation with no parent company and no nonwholly owned subsidiaries.

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STATEMENT OF THE CASE

A. Nature of the Case

Petitioner HealthSouth Rehabilitation Hospital ("HealthSouth") has petitioned for a writ of certiorari (the "Petition") to review a decision by the United States Court of Appeals for the Fourth Circuit affirming summary judgment for Respondent American National Red Cross ("Red Cross").

B. Statement of Facts

At the hearing on Red Cross's motion for summary judgment, the district court made the following findings of fact, in the light most favorable to HealthSouth. Petition *Appendix D* at 20a-23a.

The ERISA plan at issue (the "Plan") is a welfare benefits plan, self-insured by Red Cross for its employees. Red Cross is the Plan Administrator, while Aetna Insurance Company of America ("Aetna") provides administrative services pursuant to a contract with Red Cross (the "Contract"). Under the Contract, Aetna is authorized to make determinations on behalf of Red Cross with respect to benefit payments under the Plan and to pay such benefits, subject to Red Cross's right to review and modify any such determinations.

In June 1989 Red Cross employee Derrick L. Wagner completed an Employee Enrollment Form, in accordance with Plan procedures. Mr. Wagner elected to obtain medical coverage under the Plan for himself, but not for anyone else. The Medical Plan identification card (the "Plan ID Card") that Mr. Wagner received advised health care providers to contact Aetna to certify hospital admission or to verify coverage. The card further stated that while coverage remained in force, covered employees and

dependents were entitled to benefits as provided under the terms and conditions of the employer's benefits program. The card specifically stated that it did not guarantee coverage.

At the time Mr. Wagner completed the Employee Enrollment Form he was the father of a minor child, Eric Shaw, who lived with his mother, Alberta Shaw. On January 4, 1994, Ms. Shaw took Eric to HealthSouth, where he was admitted as an inpatient. Prior to Eric's admission, Ms. Shaw represented to HealthSouth that Eric was covered under Mr. Wagner's Red Cross plan. Ms. Shaw signed a document purporting to assign to HealthSouth "the right to all benefits payable from any and all insurance policies, employee benefit plans, and/or legal actions from which I am entitled to recover." In response to HealthSouth's telephone inquiry, an Aetna representative, identified only as "Kelley," informed HealthSouth that Eric was covered under the Red Cross plan. HealthSouth attempted to confirm coverage by faxing a letter (the "Confirmation Fax") to an Aetna representative, identified only as "Millie," on January 4, 1994. Throughout Eric's stay, Aetna was contacted on a weekly basis to obtain precertification for additional days of treatment. HealthSouth received no response to the Confirmation Fax until February 15, 1994, when Millie left a voice mail recording with HealthSouth stating that Eric was not covered and that prior verification had been a mistake. Two days later, Eric was discharged after having incurred $82,967 in medical bills.

C. Procedural History

In November 1995 HealthSouth filed suit in the United States District Court, District of South Carolina, bringing state law claims against Ms. Shaw and Mr. Wagner and ERISA claims against Aetna and Red Cross. HealthSouth obtained default judgments on its state law claims and settled with Aetna. In August 1995 the district court denied HealthSouth's motion to

amend its complaint to add an estoppel action under federal common law and granted summary judgment to Red Cross. The court of appeals affirmed in a published decision. *See HealthSouth Rehabilitation Hospital v. American National Red Cross*, 101 F.3d 1005 (4th Cir. 1996).

SUMMARY OF THE ARGUMENT

The issue addressed by the lower courts in this action was whether oral representations by a non-fiduciary claims processor to a hospital can estop a plan administrator from denying coverage under a welfare benefits plan. This was a narrow question that reflected the specific facts of the case. Recognizing that such an issue is unlikely to be reviewed by this Court, HealthSouth's Petition presents a far broader question for review, asking the Court to establish guidelines for determining generally when federal estoppel claims should apply in ERISA actions. Such a question is overly broad and inappropriate, since it was not addressed below.

Whether the issue is framed narrowly or broadly, it is not the subject of a pervasive conflict among the federal circuits. Because the circumstances surrounding ERISA cases vary widely, decisions among and within the circuits often vary as to whether estoppel can apply. However, HealthSouth can identify only one case, *Miller v. Taylor Insulation Co.*, 39 F.3d 755 (5th Cir. 1994), that arguably conflicts with the Fourth Circuit's decision in the present action. The arguable conflict arises from dicta in *Miller* that discusses policy issues applicable to circumstances not present in the case at hand. The *Miller* dicta cannot fairly be characterized as representing a "pervasive conflict" among the circuits.

HealthSouth also asks this Court to determine whether representations of a non-fiduciary agent made in the course and

scope of its authority bind a plan administrator/principal. The question presented in the lower courts, however, was *whether* Aetna was acting within the scope and course of its authority. In affirming the district court's finding that Aetna did *not* make a representation "in the course and scope of its authority," the Fourth Circuit plainly did not reach the issue presented by HealthSouth.

HealthSouth cites *Taylor v. The Peoples Natural Gas Co.*, 49 F.3d 982 (3rd Cir. 1995) and *Weaver v. Phoenix Life Mut. Ins. Co.*, 990 F.2d 154 (4th Cir. 1993) as being in conflict with *HealthSouth*. This comparison, however, boils down to an assertion that the Fourth Circuit misapplied properly stated rules of law. HealthSouth also tries to support its claims that Aetna could designate anyone it wanted as a plan beneficiary by quoting language from the Administrative Services Agreement between Aetna and Red Cross. The Fourth Circuit specifically found, however, that nothing in the Plan, the Red Cross/Aetna contract, or any other written document indicated that Aetna could unilaterally alter the plan by bestowing beneficiary status upon a previously non-covered individual.

REASONS FOR DENYING THE WRIT

I.

NO NEED EXISTS FOR THE SUPREME COURT TO SET GUIDELINES GOVERNING THE APPLICATION OF ESTOPPEL TO ALL ERISA ACTIONS.

A. The First Question Presented By HealthSouth In Its Petition Is Overly Broad And Was Neither Raised Nor Addressed By The Courts Below.

HealthSouth requests this Court to "set guidelines" for determining "when and under what circumstances common law

principles of estoppel should be incorporated into federal common law under ERISA." Petition at *i*, *ii*. The scope of such a question goes far beyond what was addressed in this action by the courts below and requires this Court to anticipate a wide variety of factual contexts. By seeking guidelines to govern all instances in which a party seeks to apply federal estoppel in an ERISA action, HealthSouth confuses the function of this Court with that of a regulatory agency.

HealthSouth first raised the issue of estoppel at oral arguments before the district court on Red Cross's motion for summary judgment. HealthSouth raised the issue in the context of a motion to amend its complaint by adding a federal common law estoppel claim, which the court denied, apparently on grounds of futility. In affirming the district court's denial of the motion to amend, the court of appeals addressed the following issue: under federal common law, can inaccurate oral representations by a non-fiduciary claims processor to a hospital that a non-beneficiary is covered under a welfare benefits plan estop the plan administrator from denying coverage, when the claims processor is the plan administrator's agent for the purpose of health benefit determinations? *See* 101 F.3d at 1009, 1010. The courts below were not presented with and did not address the broader estoppel question presented by HealthSouth in its Petition to this Court. Because this broader issue was not addressed below, the considerations governing review on certiorari listed in Supreme Court Rule 10 do not support the granting of HealthSouth's Petition.

B. No Pervasive Conflict Exists Among The Circuits Concerning The Application Of The Federal Common Law Of Estoppel To Erisa Actions.

HealthSouth contends that a "pervasive conflict" over the relationship between estoppel and ERISA divides the federal

circuits. As support, HealthSouth identifies three categories of cases:

> 1. those holding that the written terms of an ERISA plan cannot be modified by oral representations, Petition at 8-10;
>
> 2. those allowing estoppel claims in ERISA cases, Petition at 9, 12; and
>
> 3. those that "have left open whether estoppel may be applied in limited circumstances," Petition at 10-11.

HealthSouth's categories do not represent a conflict among the circuits, however. Several circuits are represented in more than one category. The reason, of course, is that ERISA cases arise from a wide variety of factual contexts, some of which may justify the application of estoppel and some of which may not.

HealthSouth suggests, for example, that an internal conflict exists within the Eleventh Circuit since one of its decisions rejects estoppel in an ERISA case while another allows it. *See* Petition at *i*, *comparing Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1996) *with Kane v. Aetna Life Ins.*, 893 F.2d 1283 (11th Cir. 1990). The holdings of these cases, however, are not inconsistent. *Nachwalter* refused to estop an ERISA plan administrator from denying benefits based on oral representations that would have modified the plan's written terms. 805 F.2d at 957-960. *Kane*, by contrast, estopped an administrator from denying benefits based on its agent's oral interpretation of an ambiguous plan provision. 893 F.2d at 1286. The *Kane* opinion noted that its result was premised "entirely on the language" of the particular plan at issue. *Id.*

HealthSouth's conclusory allegation of a pervasive conflict among the circuits is no more substantial than the purported internal conflict within the Eleventh Circuit. After all its categories and string cites, the Petition can identify only one case, *Miller v. Taylor Insulation Co.*, 39 F.3d 755 (7th Cir. 1994), which it contends is in conflict with the Fourth Circuit's decision in *HealthSouth*. *See* Petition at 13.

In *Miller*, an employer made a written promise to a former employee, which he accepted and relied upon, that he could continue to participate in a welfare benefits plan after his retirement. 39 F.3d at 757. *HealthSouth* is fundamentally distinguishable in several respects:

1) No promise was made in *HealthSouth*, for the Plan ID card presented to HealthSouth specifically refused to guarantee coverage. Petition *Appendix D* at 22a.

2) The representations upon which HealthSouth relied were oral, not written.

3) The representations were not made by a high ranking employee of a fiduciary but by a low level employee of a non-fiduciary agent.

4) Unlike the *Miller* plaintiff, who accepted the offer of being a plan participant, Red Cross's employee Derrick Wagner declined Red Cross's offer to enroll his son as a beneficiary.

In dicta the *Miller* court speculated that the public policy justifications for the rule against oral modifications of ERISA plans may not apply to a promissory estoppel claim arising from assurances by an employer's high-ranking representative to an employee that he is a plan participant. *Id.* The facts in

HealthSouth are clearly distinguishable from such a hypothetical case, however. More significantly, *Miller* specifically noted that its holding "would not collide with a policy against allowing oral modifications of ERISA plans," 39 F.3d at 759 — the very policy upheld by the Fourth Circuit in *HealthSouth.*

Miller and *HealthSouth* are therefore distinguishable. But even if the *Miller* dicta suggests a conflict, the two cases hardly represent a pervasive conflict among the circuits requiring this Court to promulgate a broad "set of guidelines" applicable to all ERISA cases.

II.

THE *HEALTHSOUTH* DECISION IS NOT BASED ON ERRONEOUS FACTUAL FINDINGS OR THE MISAPPLICATION OF PROPERLY STATED RULES OF LAW.

HealthSouth frames the second question it presents to this Court as whether "representations of a non-fiduciary agent made in the course and scope of its authority bind the plan administrator/principal." Petition at *ii*. The question offered for review skips the initial issue of *whether* Aetna was acting within the scope and course of its authority. The court of appeals affirmed the district court's factual finding that "Red Cross . . . did not give Aetna the authority to modify the plan so as to add beneficiaries." 101 F.3d at 1008-1009; Petition *Appendix D* at 24a-25a. The court concluded that:

> Aetna . . . does not have the authority to effect unilateral modifications to the Plan by giving erroneous information to potential

> benefit claimants like HealthSouth. Thus, nothing in the Plan, the Red Cross/Aetna contract, or any other written document before this court indicates that Aetna may unilaterally alter the plan by bestowing beneficiary status upon a previously non-covered individual.

101 F.3d at 1009. In order to reach the second question presented in the Petition, this Court would therefore have to overturn the factual findings of the courts below. Review under these circumstances is hardly appropriate. *See* Sup. Ct. R. 10.

HealthSouth contends that the court's conclusion in *HealthSouth* "ignores the common law theory of agency" adopted in *Taylor v. The Peoples Natural Gas Co.*, 49 F.3d 982 (3rd Cir. 1995). Petition at 14. By this, HealthSouth is asserting that the court misapplied a properly stated rule of law, another questionable basis for granting a certiorari petition. *See* Sup. Ct. R. 10. *Taylor* did not formulate a unique "theory" of agency but instead considered two main issues: (1) whether a non-fiduciary benefits supervisor employed by a plan sponsor could be considered the agent of a plan administrator; and, (2) whether the supervisor had actual or apparent authority to make representations on behalf of the plan administrator to the plan sponsor's employees concerning the retroactivity of an early retirement plan. The court decided that the supervisor was acting, at a minimum, with apparent authority on behalf of the plan administrator. This decision hinged on the uncontested fact that the plan participants reasonably relied on the supervisor for guidance about their retirement plan and the defendant's admission that the supervisor had actual authority to advise employees of their rights and options under the plan. *Id.* at 988-989.

In contrast, the Fourth Circuit in *HealthSouth* considered a completely different question: whether Aetna, by its oral assurances, somehow "made" Eric Shaw a beneficiary. *Id.* at 1008. The court first rejected HealthSouth's argument that Aetna possessed either actual or apparent authority to confer beneficiary status on Eric Shaw because the district court had correctly concluded that "any discretionary authority over administration of the Plan rested solely with Red Cross." *Id.* at 1008. Aetna, as a claims processor, was not a fiduciary who could alter the plan's terms. *Id.* at 1009. The court also noted that even if Aetna were a fiduciary, its oral statements would be insufficient to modify the terms of an established ERISA plan. *Id. Taylor* thus lends no support to HealthSouth's position. While the holdings in both *Taylor* and *HealthSouth* implicate the issue of a non-fiduciary agent's authority, they involve wholly dissimilar facts.

HealthSouth further attempts to bolster its claims that Aetna could designate anyone it wanted as a Plan beneficiary by quoting language from the Administrative Services Agreement between Aetna and Red Cross. Petition at 14, 15. HealthSouth fails to note that Aetna's authority to make determinations with respect to benefit payments is "subject, however, to a right of [Red Cross] to review and modify any such determination." *See* Petition *Appendix D* at 24a. As the district court concluded, HealthSouth's position "flies in the face of the clear language" quoted here. Petition *Appendix D* at 24a. The Fourth Circuit also specifically noted that "nothing in the Plan, the Red Cross/ Aetna contract, or any other written document before this court indicates that Aetna may unilaterally alter the plan by bestowing beneficiary status upon a previously non-covered individual." *HealthSouth*, 101 F.3d at 1009.

Finally, HealthSouth claims that "by failing to recognize Aetna as Red Cross's agent, the Fourth Circuit's decision

conflicted with its earlier decision in *Weaver*." Petition at 15. HealthSouth is again presenting an argument that was not addressed by the Fourth Circuit and asserting that the court misapplied a properly stated rule of law. *See* Sup. Ct. R. 10. In addition, besides the fact that both *Weaver v. Phoenix Life Mut. Ins. Co.*, 990 F.2d 154 (4th Cir. 1993) and *HealthSouth* are ERISA cases, it is difficult to determine how they can be compared. *Weaver* never discusses agency and the two cases address completely different issues.

Weaver involved an insurance company that denied benefits to a participant and a beneficiary and failed to provide the "specific reason" for the claim denial as required under ERISA and the corresponding regulations. *Id.* at 157. The insurance company sought to avoid responsibility by noting that the standards on which an independent health care utilization review firm based its decision, and which would provide the specific reasons for the claim denial, were unavailable because they were the review firm's proprietary information. *Id.* at 157. The court held that "[p]lan administrators may not evade their responsibility under ERISA by contracting to third parties the obligations they have under ERISA" and must instead ascertain the specific reasons for the denial of claimed benefits and provide such reasons to the beneficiary. *Id.* at 158. In contrast, HealthSouth never asserted that Red Cross was withholding information from a participant or beneficiary and Red Cross has not sought to avoid responsibility of any kind by claiming that Aetna held proprietary information that was not available to Red Cross. Once again, HealthSouth relies upon a case that does not provide relevant authority.

CONCLUSION

For the reasons discussed above, HealthSouth's Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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